PRINTED: 11/23/2020 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING IL6010441 10/09/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3900 STEARNS AVENUE** STEARNS NURSING & REHAB CENTER **GRANITE CITY, IL. 62040** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Final Observations S9999 Statement of Licensure Violation: Complaint #2047840/IL127411 1 of 1 Violation 300.610a) 300.1210b) 300.1210d)3) 300.1220b)2) 300.3240a) Section 300.610 Resident Care Policies The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Section 300.1210 General Requirements for

and dated minutes of the meeting.

Nursing and Personal Care

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6010441		B. WING		10/09/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
STEARN	S NURSING & REHA	CENTER		ARNS AVENI CITY, IL 620			
(X4) ID PREFIX TAG		TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETE DATE
S9999	care and services to practicable physical well-being of the research resident's complan. Adequate and care and personal care and personal care needs of the remeasures shall inclifollowing procedure	shall provide the pattain or maint land pattain or maint land pattain or maint land pattain and pattain are shall be proved total nursing are shall be proved total nursing are stated at a minimus: subsection (a), include, at a minimus paracticed on a state or a minimus pattain are practiced on a state or a	ain the highest sychological lance with dent care vised nursing vided to each ative um, the general mum, the	S9999			
	resident's condition emotional changes, determining care re further medical eva made by nursing staresident's medical re Section 300.1220 Services	as a means for quired and the reluction and treat aff and recorded ecord. Supervision of Name and supervise are as a supervise and supervise are as a supervise are a supervise are as a supervise as a supervise as a supervise are as a supervise as a supe	al and analyzing and need for ment shall be in the ursing				
	2) Overseeing assessment of the include medically diffunctional status, see	efined conditions	s, which s and medical				

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impairments, nutritional status and requirements,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6010441	B. WING		10/09/2	
NAME OF I	PROVIDER OR SUPPLIER		, .	STATE, ZIP CODE	1000	.072020
STEARN	S NURSING & REHAE	K CENTED	ARNS AVEN CITY, IL 62	· 		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999		<u> </u>	
Si	psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.					
	Section 300.3240 /	Abuse and Neglect				
		_		*S		
53	employee or agent	censee, administrator, of a facility shall not abuse or (A, B) (Section 2-107 of the		V		
	These Requirement by:	ts are not met as evidenced		W	•	
***	failed to complete ti the physician of a c vital signs and to pr timely manner for 1 for care and service failure resulted in R ventilator and dying	and record review the Facility mely assessments, to notify hange of condition, to monitor ovide medical treatment in a of 3 residents (R48) reviewed as in the sample of 8. This 48 being hospitalized on a on 8/28/2020. This past urred from 8/2/2020 to				
÷.	Findings include:			**		
55 8	documents a diagno	der Sheet (POS), August 2020 osis of Alzheimer disease, erebral vascular accident, oulmonary disease.				
	R48's Face Sheet of COVID-19 (undated	locuments a diagnosis of d).				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6010441 B. WING 10/		10/0	/09/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STEARN	S NURSING & REHAI	BCENTER	ARNS AVEN	- -		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROPRIEM (CROSS-REFERENCE)	DBE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	at 2 PM, "Spoke with where (R48) was a pneumonia." The N why R48 was being what symptoms R4	s dated 8/1/2020 documents, th (nurse) at local hospital dmitted with diagnosis of furses Notes do not document sent out to the hospital, or 8 was displaying before being bital, or what her vital signs	.0	g\$	77	
	R48's Nurses Notes do not have any other documentation for 8/1/2020. There was no documentation in R48's medical records of vitals being performed on R48 for 7/30/2020 or 7/31/2020. The last vitals documented for R48 was on 7/29/2020 at 11:15 PM, and there were no other vitals documented as being taken for R48 on 8/1/2020.				<i>10</i>	
EI 24	Preventionist stated especially those wh to have vitals taken documented. We have	:32 AM, V13, Infection Control d, "we expect all residents to are positive with COVID-19 every 4 hours and ad some issues with staff not nink we are now on top of				
8	R48's POS dated August 2020 does not document R48 went out to the hospital on 8/1/2020.			Υ Æ	1	
	at 12:32 PM, docun from the nursing ho status. Patient app at the nursing home responsive, short of	ords "arrival date of 8/1/2020 ments, "79-year-old sent in time because of altered mental arently was seen this morning and found to be less of breath, and Emergency MS) was called. Patient does the a this morning."		85 93	×	

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
:		11 0040444	B. WING			
<u> </u>			B. WING		10/0	9/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
STEARN	S NURSING & REHA	BCENTER	ARNS AVEN			
	CUMMARYOTA	·····	CITY, IL 62			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETE DATE
S9999	Continued From pa	age 4	S9999			
	hospital document	Results taken at the local R48 had a positive COVID-19 12:50 PM, and it was verified PM.				
	documents a final of pneumonia. The re- looked considerable discharge than on t	cords dated 8/2/2020 diagnosis of COVID-19 and ecords document, "(R48) e better on the day of the the 3rd (August) so at this el comfortable in discharging sing home."				
	"resident readmitte Orders sent to pha No signs or sympto	s dated 8/5/2020 at 4:24 AM, d from (local hospital) New rmacy, assessment complete. oms of distress noted, will and monitor residents.				
	notes in charts unti	t does not contain any more I 8/14/2020 including daily vital ned and documented by the		8		F
	stated, "Initially my because her Oxyge her out to the hospi hospital and was proported in 8/1/2020. (R48) she got better so the oxygen dropped agout again to the hospical and keeping a content of the state of the	25 AM, V53, Family of R48 mom went out to the hospital en was dropping, and they sent ital she was tested at the ositive for COVID-19. That was) while she was in the hospital, ney sent her back to the facility 15 days later (August 20) her gain and they had to send her spital but this time she never t sure they were monitoring close eye on her condition.				
	Nurses Notes date	d 8/20/2020 (no time				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6010441	B. WING	<u></u>	10/0	9/2020
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET AD		DRESS, CITY, 8	STATE, ZIP CODE		
STEARN	S NURSING & REHA	B CENTER	ARNS AVEN			
044110	SHMMADV STA	ATEMENT OF DEFICIENCIES	CITY, IL 62	PROVIDER'S PLAN OF CORRECTION	DN .	0.00
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	Continued From pa	age 5	S9999		_	
	documented) R48's	s oxygen levels were				
	documented at 72.	"Resident has visible distress				
		his nurse entering room this				12
		Nursing Assistant pulled and elevated, Head of Bed				
	(HOB) non-rebreat	her applied, Oxygen levels	,			
		nis nurse notified on call ers received to send resident	10			
		resident transferred to				
	hospital. Family no	tified and Doctor notified of				
		Report called to (local hospital). ords do not document any other				
	vitals were taken th					
	D401 D00 444 40	NO 10000 110 14 F				
	R48's POS dated 8 Room for evaluatio	8/20/2020, "Send to Emergency on and treatment."				
1	R48's Hospital Rec	ords dated 8/21/2020				!
		is a 79 year old Caucasian				,
		of dementia, hypertension, accident, (CVA), who was				:
	reportedly nonverb	al and sent to the emergency				
		home) due to shortness of	į.			
		is obtained from the chart as ovide related to chronic				
		he was found to be hypoxic in				
		m and was placed on 10 liters				
		s recently found to be on admission from August 1 to		101		
		as admitted to the Intensive		110		
		further management. Reason				
	for consultation, Ac failure."	cute hypoxemic respiratory				
	R48's Hospital Red	cords dated 8/28/2020				
	"79-year-old female	e with COVID-19, hypoxemic				
		who initially improved and was annula but later developed				
		rial Fibulation (Afib) and				
		and mechanical ventilation.				

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STATE FORM

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Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: __ B. WING 10/09/2020 IL6010441 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3900 STEARNS AVENUE** STEARNS NURSING & REHAB CENTER **GRANITE CITY, IL 62040** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG DEFICIENCY) S9999 S9999 Continued From page 6 She had multiple comorbidities and was frail. This morning she developed cardiac arrest and protocol was implemented but she passed away at 9:26 AM." On 10/6/2020 vital sign sheets were requested for R48 and no vital sign sheets were produced for R48 other than her vitals taken on the selective nurse's notes. On 10/8/2020 at 2:11 PM, V60, Nurse Practitioner stated. " For any resident who test positive we expect the facility to monitor vitals. listen to lung sounds, do temperatures, heart rate, Blood pressure, pulse, oxygen levels, to look at the residents for any signs or symptoms of shortness of breath, any respiratory issues going on, look at their level of conscientiousness, (R48) had dementia and when she came back from the hospital! know she was placed on the COVID unit. I was not there every day, but I would expect them to monitor her condition and document their results." The State of Illinois Certificate of Death Worksheet, dated 8/31/2020 documented R48 cause of death, Cardiac arrest and COVID-19 on 8/28/2020. The CDC website page, "Responding to Coronavirus (COVID-19) in Nursing Homes, Updated 4/30/2020, document the facility should implement the following for residents who have tested positive for COVID-19 or who are experiencing the symptoms of COVID-19: Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturations via pulse oximetry and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections; and Consider

PRINTED: 12/16/2020 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING IL6010441 10/09/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3900 STEARNS AVENUE** STEARNS NURSING & REHAB CENTER **GRANITE CITY, IL 62040** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 7 S9999 S9999 increasing monitoring of symptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms." The Policy provided by the facility for "COVID Monitoring" dated 7/7/2020 documents, "It shall be the policy to utilize accepted Infection Control Methods to prevent and Control the Spread of a respiratory illness, caused by Novel Coronavirus (COVID-19). Older adults and patients with comorbid conditions are at an increased risk for more severe illness. Actively monitoring for Coronavirus is an important aspect of the ongoing infection control program. Temperatures are taken daily of all residents and staff." This policy was outdated and does not follow the Center for Disease guidelines for increased monitoring for at least 3 times daily. (A)

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